MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13H)

CERTIFICATE OF DEATH

00544

Reg. Dist. No. 166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Garrett, Maryland.
City or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Rudolph Beckman.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 3d, 1865

8. AGE: Years	Months	Days	If less than one day
79	1	6	hrs. min.

9. Birthplace Kitzmiller, Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Rudolph Beckman.
13. Birthplace Germany

MOTHER
14. Maiden name Elizabeth O'Brien.
15. Birthplace Garrett County.

16. Informant Russel Beckman.
Address Oakland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 11/45 (month) (day) (year)
Cemetery or crematory Oakland Cemetery.
Location Oakland, Maryland.

18. Funeral director Emroy D. Bolden.
Address Oakland, Maryland.

19. Jan - 10 - 1945 (Date rec'd by registrar) Julia Rowe Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9th 1945 at 5:30 PM.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-24-44 1945 to 1-9-45 1945 and that I last saw him alive on 1-9-45 1945

Immediate cause of death	DURATION
Chronic Bronchitis	3 week
Due to Chronic Nephritis	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Oakland, Maryland Date signed 1-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

00545

Reg. Dist. No. 161

1. PLACE OF DEATH:

County: Garrett

City or town: Rural-Friendsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ?

Hospital, institution, or street address where death occurred:
Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Rural-Friendsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Friendsville, Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Anna Belle Fike

3. (b) Social Security Number:

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Anna Belle Fike

7. Birth date of deceased (mo., day, yr.): Aug. 31, 1860

6.(c) If alive, give age: 84 years

8. AGE: Years: 84 | Months: 4 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business:

MOTHER / FATHER

12. Name: M. F. Tuttle

13. Birthplace: Md

MOTHER

14. Maiden name: Vanscoyoc

15. Birthplace: Md

16. Informant: Fred Fike

Address: Friendsville

17. (Burial, cremation, or removal. Which?) Date thereof: Jan 5 1945 (month) (day) (year)

Cemetery or crematory: Sand Spring Md

Location: Sand Spring

16. Funeral director: W. H. Duckworth

Address: Friendsville

19. 1-5-45 (Date rec'd by registrar) Isaac Rush Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 3, 1945, at 3:20a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1942 to Jan. 3, 1944

and that I last saw her alive on Sept. 6, 1944

Immediate cause of death	DURATION
Congestive heart Failure	?
Due to: Endocraditis	?
Due to: Arteriosclerosis	?
Other conditions: Senile Dementia	
Chronic nephritis	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. J. Glover, M. D.
M. D. or other

Address: Friendsville, Md Date signed 1-4-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

00546

Reg. Dist. No. 166

1. PLACE OF DEATH:
County: Garrett
City or town: Mt. Lake Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
Kisers Nursing Home
How long in hospital or institution? 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: Grant
City or town: Bayard
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: -----

3.(a) FULL NAME: John Henry Forsyth

3.(b) Social Security Number: ----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sarah Virginia Winters Forsyth
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): June 13, 1864

8. AGE: Years	Months	Days	If less than one day
80	7	6	....hrs. ....min.

9. Birthplace: Preston Co., W. Va. (Town, county, and state)
10. Usual occupation: Coal Miner
11. Industry or business: Bituminous Coal Mines
FATHER 12. Name: Alexander Forsyth
FATHER 13. Birthplace: Scottland
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace:
16. Informant: James R. Forsyth
Address: 319 So. Newcreek St.; Balto., Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 20, 1945 (month) (day) (year)
Cemetery or crematory: Bayard Cemetery
Location: Bayard, W. Va.
18. Funeral director: Herbert C. Leighton
Address: Oakland, Md.
19. Jan. 19 1945 (Date rec'd by registrar) Julius A. Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18, 1945 19.... at 12:10P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-14-45 19.. ih to 1-18-45 19.. im and that I last saw h.. alive on 1-13-45 19..

Immediate cause of death: General Debility Heart Tatack — DURATION
Due to:
Due to: Valvular Heart Lesion
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Oakland, Md Date signed: 1-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

00547

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett

City or town Oakland, Maryland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life time

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County County.

City or town Oakland, Maryland. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Eleanor Frantz.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Edward J. Frantz.

Deceased 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 24th, 1864

8. AGE: Years	Months	Days	If less than one day
80	2	21	hrs. min.

9. Birthplace Garrett County.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name James A. Dunham.

13. Birthplace Pennsylvamia.

MOTHER 14. Maiden name Elizabeth Morris.

15. Birthplace Pennsylvania.

16. Informant Miss Cora Frantz.

Address Oakland, Maryland.

17. Burial Date thereof January 17/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakland Cemetery.

Location Oakland, Maryland.

18. Funeral director Emroy D. Bolden.

Address Oakland, Md.

19 Jan - 16 - 1945 Julian A Rowan
(Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1945, at 10:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1944, to Jan. 1945, and that I last saw her alive on Jan. 14 1945.

Immediate cause of death	DURATION
Generalized Arteriosclerosis	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edwin Bamgardner M. D. or Other

Address Oakland, Md. Date signed 1/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00548

CERTIFICATE OF DEATH

Reg. Diat. No. 161

1. PLACE OF DEATH: County: Garrett

City or town: Near Friendsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All her life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Near Friendsville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Louise Friend

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: Never Married

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 28- 1885

8. AGE: Years: 59 | Months: 10 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Helps around home

11. Industry or business

FATHER — 12. Name: Andrew Friend

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Mary Lish

MOTHER — 15. Birthplace: Md

16. Informant: Anna Friend

Address: Friendsville Md

17. (Burial, cremation, or removal? Which?) Burial Date thereof: Jan 28-45 (month) (day) (year)

Cemetery or crematory: Bloomington Rose

Location: Near Friendsville

18. Funeral director: H. H. Sawyer

Address: Friendsville Md

19. Jan 27 1945 (Date rec'd by registrar) Ira L. Rush, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 25 19 45, at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 19 42 to Jan. 25 19 45

and that I last saw her alive on June 10 19 44

	DURATION
Immediate cause of death: Cerebral Hemorrhage	?
Due to: Arteriosclerosis	?
Due to:	
Other conditions: Nephritis	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. J. Glover M.D. M. D. or other

Address: Friendsville, Md Date signed: 1-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00549

Reg. Diat. No. 161

1. PLACE OF DEATH:
County: Garrett
City or town: Selbysport Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infant, give residence of mother)
State: Md. County: Garrett
City or town: Friendsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Webster . Friend

3.(b) Social Security Number 0

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 14, 1871

8. AGE: Years 73 | Months 6 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace Md. Garrett (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name H. S. Friend
13. Birthplace Md

MOTHER
14. Maiden name Phoebe Ellen Lauchrey
15. Birthplace Accident, Md.

16. Informant Nezzie Friend
Address Selbysport Md.

17. Burial, cremation, or removal Burial Date thereof Jan. 6. 45 (month) (day) (year)
Cemetery or crematory Friendsville Md
Location

18. Funeral director H. H. Swaney
Address Friendsville Md

19. Jan 6. 1945 (Date rec'd by registrar) Ira C. Rush Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1945, at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 8 1941, to Jan. 3 1945 and that I last saw him alive on Nov. 12 1944

Immediate cause of death	DURATION
Carcinoma of descending colon	10 years
Due to ?	
Due to	
Other conditions Senility.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. I. Glover M.D. M. D. or other
Address Friendsville, Md. Date signed Jan. 5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

00550

Reg. Diat. No. 171

1. PLACE OF DEATH:
County Garett
City or town R.D. Accident
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Garett
City or town R.D. Accident
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Flavius Josephus Glotfelty

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Elizabeth Glotfelty
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15 1860

8. AGE: Years	Months	Days	If less than one day
84	2	18	hrs. min.

9. Birthplace R.D.1 Accident (Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business

FATHER
12. Name Nimrod Glotfelty
13. Birthplace Salisbury Pa

MOTHER
14. Maiden name Magdalena Broadwater
15. Birthplace R.D.2 Grantsville Md

16. Informant Mrs Myrtle Broadwater
Address Grantsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-6-1945 (month) (day) (year)
Cemetery or crematory Glotfelty
Location R.D.1 Accident Md

18. Funeral director Wm A Winterberg
Address Grantsville Md

19. Jan. 5 1945 (Date rec'd by registrar) J.B. Emery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1945 at 4.30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Paralysis y Brain Cords	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B.J. Baumgartner M D
M. D. or other
Address Oakland Md Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

00551

CERTIFICATE OF DEATH

Reg. Diat. No. 171

1. PLACE OF DEATH:
County: Garett
City or town: Rural Near Jennings
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garett
City or town: Rural Near Jennings
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Louis Hoover

3.(b) Social Security Number: 213-18-2632

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Stella M. Hoover
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): July 15-1886

8. AGE: Years	Months	Days	If less than one day
58	6	--	..... hrs. ..... min.

9. Birthplace: Rural Near Jennings Garet Co-Md
(Town, county, and state)

10. Usual occupation: Coal Miner

11. Industry or business

FATHER
12. Name: Chancy Hoover
13. Birthplace: Near Jennings Md

MOTHER
14. Maiden name: Elmaria Bittinger
15. Birthplace: Near Jennings Md

16. Informant: Mrs Stella M. Hoover
Address: Jennings Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-17-1945 (month) (day) (year)
Cemetery or crematory: Charles Hoover
Location: Near Jennings Md

18. Funeral director: Wm Winterberg
Address: Grantsville Md

19. Jany. 16 1945 (Date rec'd by registrar) J.B. Emory Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 15 1945, at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 13 1945 to Jan 15 1945
and that I last saw him alive on Jan 13 1945

Immediate cause of death	DURATION
a. Cerebral hemorrhage	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. K. Davis M.D.
M. D. or other
Address: Grantsville Date signed: Jan 17

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

00552 / 66
Reg. Dist. No.

1. PLACE OF DEATH:
County: Garrett
City or town: Hutton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Hutton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Benjamin Hamilton Long

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eva Johnson Long
6.(c) If alive, give age: 68 years
7. Birth date of deceased (mo., day, yr.): June 6, 1863.
(June 6, 1863)

8. AGE: Years: 81 | Months: 7 | Days: 22 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Mt. Olivet, Pa.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: General
FATHER 12. Name: Gidion Long
13. Birthplace: Fredrick, Md.
MOTHER 14. Maiden name: Mary Keener
15. Birthplace: Fredrick, Md.
16. Informant: Mrs. Eva Johnson Long
Address: Hutton, Md.
17. Removal and Burial (Burial, cremation, or removal. Which?) Date thereof (mouth) Jan. (day) 30, (year) 1945
Cemetery or crematory: Monongahela
Location: Mapletown, Pa.
18. Funeral director: Kilbadon
Address: Terra Alta, W.Va.
19. 1/29 19 45 Julia Rowan (Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH: January 28th 19 45 at 3:40 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 24 19 44 to 19
and that I last saw h[illegible] alive on December 24 19 44

Immediate cause of death	DURATION
Not Known	
Due to: Carcinoma of Stomach 2 yrs.	
Due to:	
Other conditions: Retention Urine due to obstruction Prostate	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harold C. Miller, M.D.
M. D. or other
Address: Eglon, W.Va. Date signed 1/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Baumgartner 00553 Reg. Dist. No. 2166.

1. PLACE OF DEATH:
County Garrett
City or town Oakland, Maryland. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Garrett
City or town Oakland, Maryland. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martha McComas McIntire.

3.(b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Married.
6.(b) Name of husband or wife Paul W. McIntire
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 16th, 1903
8. AGE: Years 41 Months 9 Days 3 If less than one day hrs. min.
9. Birthplace Oakland, Maryland. (Town, county, and state)
10. Usual occupation House wife
11. Industry or business

FATHER
12. Name Henry Wheeler McComas.
13. Birthplace Oakland, Maryland.

MOTHER
14. Maiden name Annie West.
15. Birthplace Swanton.

16. Informant Mrs. Nelle Lawrence.
Address Oakland, Maryland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 22/45 (month) (day) (year)
Cemetery or crematory Oakland Cemetery.
Location Oakland, Maryland.
18. Funeral director Emroy D. Bolden.
Address Oakland, Maryland.
19 Jan. 21- 1945 (Date rec'd by registrar) Julia A. Rowan Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 th 1945, at 11:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 1943, to Jan 19 1945 and that I last saw her alive on Jan 18 1945

Immediate cause of death Carcinoma of breast with metastasis to
Due to Lung - Liver, neck
Due to
Other conditions
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations Carcinoma
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. I. Baumgartner M.D. M. D. or other
Address Oakland Md Date signed Jan 20-1945

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00554

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH:
County: Garett
City or town: Jennings
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garett
City or town: Jennings
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry Platter

3.(b) Social Security Number: None

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Annie Handwerk
6.(c) If alive, give age: 71 years
7. Birth date of deceased (mo., day, yr.): March 21-1872
8. AGE: Years: 72 Months: 9 Days: 25 If less than one day: hrs. min.
9. Birthplace: Rural Near Bittinger Garett Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
12. FATHER Name: Henry Platter
13. FATHER Birthplace: Germany
14. MOTHER Maiden name: Rachael Bittinger
15. MOTHER Birthplace: Bittinger Md
16. Informant: Finton Platter
Address: Grantsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof I-19-1945 (month) (day) (year)
Cemetery or crematory: Bittinger
Location: Bittinger Md
18. Funeral director: Wm Winebrenner
Address: Grantsville Md
19. Jan 18 1945 (Date rec'd by registrar) Esther Broadwater Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 16 1945 at 12:00 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Jan 16 1945 and that I last saw him alive on Jan 14 1945

Immediate cause of death	DURATION
Carcinoma of Rectum	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: N. L. Davis M.D. M. D. or other
Address: Grantsville Date signed: Jan 17

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (178-B)

CERTIFICATE OF DEATH

00555

Reg. Dist. No. 162

1. PLACE OF DEATH:
County: Garett
City or town: R.DI Grantsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa County: Somerset
City or town: Rural Wellersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clyde Edgar Scell

3.(b) Social Security Number: 215-10-1293

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Margiret Scell
B.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): Febuary 7 -I9I2

8. AGE: Years	Months	Days	If less than one day
32	II	6	hrs. min.

9. Birthplace: Elk Lick T. S. Somerset Co-Pa
(Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business

FATHER
12. Name: Howard F. Scell
13. Birthplace: XXXXXXX Missouri

MOTHER
14. Maiden name: Anna Klink
15. Birthplace: Elk Lick T.S. Somerset Co Pa

16. Informant: Mrs Margiret Scell
Address: Wellersburg Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof I-I6-I945 (month) (day) (year)
Cemetery or crematory: Fink
Location: On Glenco Pa Road

18. Funeral director: Wm Wintersberg
Address: Grantsville Md

19. Jan 14 1945 Ethel Broadwater
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 13 1945 at 4 H. 20 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis-passing	
Due to	
Man went to sleep in Cab of Truck with motor running	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of injury: Jan 13 1945
Where did injury occur? Garrett (City or town) (County) Md (State)
Injured at home, farm, industry, public place (where)? On Highway 40
Means of injury: Injured at work? Yes

23. SIGNATURE: W. D. Davis M.D.
M. D. or other
Address: Grantsville Md Date signed: Jan 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

00556

Reg. Diat. No. .....

1. PLACE OF DEATH:
County Garrett
City or town Mt. Lake Park,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred: Kisers Nursing Home
How long in hospital or institution? 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Mt. Lake Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION) -----
2.(a) If veteran, name war .....

3. (a) FULL NAME Eliza Schooley

3. (b) Social Security Number ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife -----

6.(c) If alive, give age ---

7. Birth date of deceased (mo., day, yr.) April 25, 1855

8. AGE: Years	Months	Days	If less than one day
89	8	13	.....hrs. .....min.

9. Birthplace Garrett Co., Md. (Town, county, and state)
10. Usual occupation House work
11. Industry or business in Homes
FATHER 12. Name William Schooley
13. Birthplace Unknown
MOTHER 14. Maiden name Clarissa Schrock
15. Birthplace Unknown
16. Informant Thomas O. Schooley
Address Mt. Lake Park, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 10, 1945 (month) (day) (year)
Cemetery or crematory Deer Park Cemetery
Location Deer Park, Maryland.
18. Funeral director Herbert C. Leighton
Address Oakland, Maryland.
19. Jan-9-45 (Date rec'd by registrar) Julia Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1945 19..... at 9:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-2-44 19..... to 1-7-45 19.....
and that I last saw her alive on 1-5-45 19.....

Immediate cause of death	DURATION
Cerebral Hemoorhage	1 hour
Due to	
Arterio sclerosis and Chronic Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Edward E. Johnson M. D. or other
Address Oakland, Md. Date signed 1-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. Dol 114557, 166

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

T

1. PLACE OF DEATH:

County: Garrett

City or town: Near Oakland,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Near Oakland, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Harriett J. Sines.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Henry B. Sines

Deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 6th 1871

8. AGE: Years	Months	Days	If less than one day
73	8	14	..... hrs. ..... min.

9. Birthplace: Hazelton, W. Va.

(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER

12. Name: Urias Mankis.

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Perry Sines.

Address: Oakland, Maryland. Route

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan/23/1945 (month) (day) (year)

Cemetery or crematory: Dunkard Bretheran Cemetery

Location: Swallow Falls, Md.

18. Fuoeral director: Emroy D. Bolden.

Address: Oakland, Maryland.

19. Jan-22. 19 45 (Date rec'd by registrar) Julia A Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20th, 1945 6:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-7-44 19 to 1-20-45 19 A. M.

and that I last saw her alive on 1-16-45 19

Immediate cause of death	DURATION
Acute Heart attach	
Due to: Valvular lesion and Chronic Ndphritis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the followiog:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, lodusiry, public place (where?)

Meaos of injury (Edward E. Sollers) Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Oakland, Maryland Date signed 1-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

00558.

Reg. Dist. No. 166

1. PLACE OF DEATH:

County: Garrett

City or town: Deer Park

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Deer Park Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War I

3. (a) FULL NAME: Edward Ray Thrasher

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): October 28, 1896

8. AGE:

Years	Months	Days	If less than one day
48	2	8	hrs. min.

9. Birthplace: Deer Park, Maryland (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER — 12. Name: William M. Thrasher

13. Birthplace: Winchester, Va.

MOTHER — 14. Maiden name: Elizabeth Jankey

15. Birthplace: Piedmont, W. Va.

16. Informant: Mrs. Albert Thrasher

Address: Oakland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 7 1945 (month) (day) (year)

Cemetery or crematory: Deer Park

Location: Deer Park, Md.

18. Funeral director: Emroy D. Bolden

Address: Oakland, Md.

19. Jan. 6, 1945 (Date rec'd by registrar) Julia Rowan, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5 1945, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Examined after death 19 to 19,

and that I last saw h alive on 19

Immediate cause of death	DURATION
Fourth degree burns entire body	
Due to: Destruction of house by fire.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 1/5/45

Where did injury occur? Deer Park, Garrett, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Burns Injured at work? No

23. SIGNATURE: E. Irving Baumgartner M.D. Prov. Med. Exam. M. D. or other

Address: Oakland Md. Date signed: 1/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING